IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION

GLEN A. KEEHN, Plaintiff, vs. WILLIAM A. HALTER, Acting Commissioner of Social Security[1], Defendant.	No. **C00-3064-MWB** **REPORT AND RECOMMENDATION**

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[1]This case was filed originally against Kenneth S. Apfel, who was at that time Commissioner of the Social Security Administration ("SSA"). On January 20, 2001, William A. Halter became Acting Commissioner of the SSA, and he is hereby substituted as defendant in this action. *See* Fed. R. Civ. P. 25(d)(1).

I. INTRODUCTION

The plaintiff Glen A. Keehn ("Keehn") appeals the denial of his claim for Title II disability insurance benefits. Keehn argues the administrative law judge ("ALJ") erred in (1) relying on an incomplete hypothetical question; (2) improperly evaluating the testimony of Keehn and his wife; and (3) improperly evaluating the medical evidence. The Commissioner resists Keehn's claims, asserting the ALJ's decision was based on substantial evidence in the record.

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

Keehn filed an application for disability insurance benefits on April 22, 1998, alleging a disability onset date of September 1, 1996. (R. 118-20) The application was denied initially (R. 85, 97-100), and upon reconsideration. (R. 86, 103-06) Keehn then requested a hearing, which was held in Mason City, Iowa, before ALJ John P. Johnson on May 4, 1999. (R. 41-82) Attorney Blake Parker represented Keehn at the hearing. Keehn, his wife Joan, and Vocational Expert ("VE") Jeff L. Johnson appeared and testified at the hearing.

On August 9, 1999, the ALJ ruled Keehn was not entitled to benefits. (R. 10-34) On June 16, 2000, the Appeals Council of the Social Security Administration denied Keehn's request for review (R. 5-6), making the ALJ's decision the final decision of the Commissioner.

Keehn filed a timely complaint in this court on August 16, 2000, seeking judicial review of the ALJ's ruling (Doc. No. 1). Pursuant to Administrative Order #1447, entered September 20, 1999, by Chief Judge Mark W. Bennett, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B) for the filing of a report and recommended disposition. Keehn filed a brief supporting his claim on January 18, 2001 (Doc. No. 10). On March 9, 2001, the Commissioner filed his brief. (Doc. No. 11) On March 22, 2001, Keehn filed a reply brief. (Doc. No. 12)

The court now deems the matter fully submitted, and pursuant to 42 U.S.C. § 405(g), turns to a review of Keehn's application for benefits.

B. Factual Background

1. Introductory facts and Keehn's daily activities

Keehn is seeking benefits for disability due to a history of left arm and hip pain, low back problems, chronic pain syndrome, and depression. At the time of the hearing in May 1999, Keehn was forty-seven years old, married, and living with his wife and teenage daughter. (R. 46) He was about six feet tall, and weighed 182 pounds. (*Id*.) He had an unrestricted driver's license. (R. 46-47)

Keehn graduated from high school and attended one semester of junior college. (R. 48) From 1979 to 1984, he worked at a mill. (R. 63, 180, 193) From 1985 to 1987, he worked as a feed salesman. (R. 62-63, 180, 190-92) From 1987 to 1990, he performed lawn care. (R. 61-62, 180, 187-89) For one month in 1991, he drove a truck, applying liquid fertilizer. (R. 61, 180, 184-86) From 1992 to June 1995, he worked as a mill manager, mixing and grinding feed. (R. 60, 180-83) This was his last job, which he lost when the mill down-sized. (R. 60) At the time of the hearing in May 1999, Keehn had not engaged in any work for four years, except for helping a neighbor feed cattle, for about twenty minutes to a half-hour about once every two months. (R. 48-50)

Keehn testified he could not hold a job because of low back, arm, and chest pain. (R. 50) The arm pain was residual from an automobile accident in October 1983, in which Keehn broke his arm, requiring the installation of a plate and several screws in his arm. (R. 50, 63) Keehn described the arm pain as "a constant ache," and when he lifts something, "a sharp pain." (R. 51) The low back pain started sometime in the four years prior to the hearing, and was not the result of any trauma -- "It just came on." (R. 63) He described his low back pain as "a dull ache in my left hip, but then sometimes it travels across almost to my right side, and

it's just kind of a burning aching pain." (R. 51) Sometimes the low back pain travels down his left leg "all the way almost to [his] ankle." (*Id*.) He also suffers from muscle spasms in his rib cage on the left side; his ribs also were broken in the automobile accident. (R. 58) At the time of the hearing, Keehn was not receiving any medical treatment for these problems. (R. 64)

Keehn testified he is never free from pain. (R. 52) He no longer goes for walks or mows the lawn. (*Id*.) It is painful for him to drive a car. (R. 53) In an effort to alleviate his pain, he alternates between sitting in one of his two recliners and on a couch, and then he walks for a short period of time. (R. 53-54) Because of shooting pains going down his leg, he has trouble falling asleep and staying asleep. (R. 54) He has medication for sleep, but only uses it sparingly. (R. 54) He has had to give up hiking, driving, and shopping as regular activities. (R. 55) He also has given up working with antiques and refinishing furniture. (R. 66) He does not belong to any organizations he attends regularly. (*Id*.)

On a typical day, Keehn gets up in the morning between 6:00 a.m. and 6:30 a.m., watches the news, and waits for his wife and daughter to get up. (R. 56) At 8:00 a.m., after his wife goes to work and his daughter goes to school, Keehn watches television until noon. (*Id*.) In the morning, he might do some dishes or some other minor household chores. (*Id*.) Keehn will make "a sandwich or something for lunch." (*Id*.) In the afternoon, he again will watch television, or if he is "feeling fairly decent," he will "go outside and pick up some sticks. . . ." (*Id*.) Occasionally, he will drive to town to do some grocery shopping. (R. 47)

Keehn's wife comes home about 4:30 p.m, and Keehn talks with her about her day at work, eats supper, and watches television. (R. 56) Although he watches a lot of television, he gets "up and down a lot." (*Id*.) He can walk for only a quarter of a mile, or for fifteen to twenty minutes, before his left side, hip, and leg start aching, and then he has to sit down with his legs up for twenty minutes. (R. 57) Although he has good days and bad days, nine-tenths of his days are bad days. (R. 59)

Keehn testified he can lift fifty pounds with his right arm, but only up to twice a day. (R. 58) He can lift between ten and twenty pounds frequently. (*Id*.) He can stand for only twenty minutes before his back starts to stiffen up and his leg starts to ache. (R. 65) He has pain if he bends, stoops, or squats. (*Id*.) He cannot use his left arm to push or pull, and he cannot raise his left arm straight up over his head. (R. 65-66) He has no problems using either hand, but if he uses his left hand, he has pain in his left arm. (R. 65) He has no problems with memory, comprehension, stress, or getting along with others. (R. 66) He testified "getting up every morning . . . knowing you're going to be doing the same thing you did yesterday gets kind of depressing." (*Id*.)

Keehn testified he had only seen his current treating physician, Stephen D. Richards, D.O., two or three times in the preceding year, but explained this was because he could not afford treatment. (R. 64-65, 68) He testified his doctors have told him there is nothing they can do for his pain and he will "just have to live with it." (R. 68)

Keehn's wife, Joan, testified her husband cannot hold down a job because "he has a lot of pain in his left side, both in his arm, and in his leg, and in the hip area." (R. 69) According to Joan, Keehn is unable to sit for long periods of time, and is unable to drive for any distance without getting out of the car for rest periods. (R. 70) She confirmed that her husband has trouble sleeping. (R. 71)

2. Vocational expert's testimony

The ALJ first posed the following hypothetical question to the VE:

> The first assumption will be an individual who's 47, will be 48 as of tomorrow, and was 45 as of the alleged onset date of disability. He is a male. He has a high school education, and past relevant work . . . , and has the following impairments: He has degenerative disc disease of the lumbar spine with complaints of low back and leg pain, he is status post-open reduction and internal fixation of a fracture of the left humorous [sic] with

> complaints of pain, hypertension, an adjustment disorder with depressed mood, and [ ] a history of neuro-fiber mitosis, and complaints of chest pain as a result of fractured ribs, and as a result of a combination of those impairments, he has the residual functional capacity as follows: He cannot lift more than 20 pounds, routinely lift ten pounds, with no standing of more than 60 minutes at a time, no sitting of more than 60 minutes at a time, and no walking of more than three to four blocks at a time, with no repetitive bending, stooping, squatting, kneeling, crawling, or climbing, and no repetitive work with the left arm above the head, and he should not be exposed to excessive cold, and he should not be exposed to more than moderate levels of vibration. He should perform no work requiring very close attention to detail, and he should not work more than a regular pace, using three speeds of pace being fast, regular, and slow. Would this individual be able to perform any jobs he previously worked at either as he performed them, or as it is generally performed within the national economy?

(R. 76-77) The VE responded that the hypothetical man would not be able to perform any of his past work activity, but would have skills that could be transferred to other work within the national economy, such as those associated with sales, customer relations, or maintaining records. The VE said those skills "could be transferred to the position of a telephone solicitor . . . listed at the sedentary level, approximately 1,00[0] positions in Iowa, [and] 200,000 positions nationally." (R. 77)

The ALJ then posed a second hypothetical question to the VE:

> My next hypothetical would be an individual of the same age, and sex, education, and past relevant work, and impairments as previously specified, and this would be an individual who would have the residual functional capacity as follows: This individual could not lift more than ten to 20 pounds, routinely lift five to ten pounds, with no standing of more than 20 minutes at a time, no sitting of more than 15 to 20 minutes at a time, and no walking of more than 15 to 20 minutes at a time, with no repetitive bending, stooping, or squatting, no repetitive pushing or pulling or working with the arm overhead on the left.

(R. 77-78) The VE responded that the hypothetical man would not be able to perform any of his past work activity, and because of the standing and sitting limitations, also would be precluded from all competitive employment. (R. 78)

The ALJ's third hypothetical question was as follows:

> My next hypothetical would be an individual of the same age, and sex, education, and past relevant work, and impairments as previously specified. And this would be an individual who would have the residual functional capacity as follows: This individual could not lift more than ten pounds, ten to 20 pounds, routinely lift ten pounds, no walking, walking is limited to less than one block, sitting is limited to 20 minutes at a time, standing for 15 minutes at a time . . . , sitting and standing and walking of less than two hours of an eight hour day, with the individual needing to take periods of walking around during an eight hour day of 20 minutes, or ten minutes approximately every 20 minutes. The individual would need unscheduled breaks, one every hour for 15 minutes. He needs to sit with his legs elevated, higher than the heart. He needs to be working at a low stress job with constant interference with attention and concentration.

(R. 78-79) The VE responded that the hypothetical man would not be able to perform any of his past work activity, and would be precluded from all competitive employment. (R. 79-80)

In response to questions from Keehn's attorney, the VE stated that under the ALJ's first hypothetical question, if Keehn could not work at more than a "slow pace" instead of a "reasonable pace," or if Keehn suffered from constant pain that would adversely affect his ability to maintain concentration and attention for extended periods of time, all competitive employment would be precluded. (R. 80-81)

3. Keehn's medical history

On October 14, 1983, Keehn was in a motor vehicle accident and suffered a fractured left upper humerus. (R. 252) He also complained of pain in the left side of his chest. (*Id*.)

Over the next few weeks, he continued to complain of pain in his chest, and was diagnosed as suffering from a flail chest,[2] with lung contusion. (R. 247-48) On December 13, 1983, after reviewing x-rays, Keehn's doctor determined his chest pain was from "rib fractures with marked overlapping of the ribs." (R. 246) By January 9, 1984, Keehn was "doing well," but was continuing to have pain and other problems in his left shoulder and his chest. (243-43) On July 24, 1985, he was diagnosed with "chronic pain secondary to rib fractures and humeral fracture." (R. 243) His medical records and work history were uneventful for the next thirteen years.

On April 8, 1988, during a DOT physical, Keehn complained to his doctor, Kenton K. Moss, M.D., of the Kossuth Regional Health Center, of continuing "discomfort in the left chest and abdomen from previous rib fractures and injury when he was driving a truck." (R. 241) Keehn denied any chest pain. (*Id*.) On August 14, 1989, he complained to Dr. Moss of pain in his left arm for the preceding three weeks. (*Id*.) Dr. Moss noted the following:

> He denies any new recent injury to [the left arm]. This is the arm that has the plate in it from his previous chest and arm trauma. He has difficulty lifting with abduction type of movement. He points to the area just at the distal tip of the plate as causing him the most discomfort.

(*Id*.) Upon examination, Dr. Moss observed the following:

> Exam reveals a scar over the anterior biceps lift arm from previous surgery. Abduction causes him some discomfort. There is tenderness along the anterior joint line and in the area just below the deltoid muscle. X-ray reveals the plate intact with significant bony hypertrophy from his healed fracture. No loosening of the plate or screws appreciated.

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[2]His chest had abnormal mobility. *See Dorland's Illustrated Medical Dictionary* (27th ed. 1988) ("*Dorland's*"), 637.

(*Id*.) Keehn was placed on Indocin[3] and directed to report back to the doctor if there was no improvement in the next ten days. (*Id*.) The medical records do not reflect that Keehn reported back to his doctor.

On December 3, 1990, Keehn had another DOT physical, and his health was reported as normal, except he was cautioned about his heavy smoking (two packs a day), his heavy use of caffeine (eight cups of coffee a day), and hypertension. (R. 239) He was on no medication at the time. (*Id*.)

Keehn had a normal "pre-employment" physical on March 20, 1992. (R. 236-38) He denied chest pain, and stated he "has some discomfort in the left shoulder at the end of the work day, but is able to [do] everything he needs to." (R. 238)

Keehn last worked in June 1995. (R. 180) He alleges a disability onset date of September 1, 1996. (R. 118) On September 7, 1996, Keehn complained to Dr. Moss of "discomfort in his left hip and ankle." (R. 235) He stated that about a week earlier, he was lifting some iron while working[4] and noticed some pain after that. (*Id*.) He had seen a chiropractor, with no relief of his symptoms. (*Id*.) Keehn denied numbness or tingling of the lower extremities, but stated he had difficulty straightening his leg. Dr. Moss found no localized weakness, and x-rays of Keehn's lumbar spine were normal. (R. 235, 255-56)

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[3]"[A] non-steroidal drug with anti-inflammatory, antipyretic [fever reducing] and analgesic properties." *Physician's Desk Reference* (50th ed. 1996) ("*PDR*"), 1681.

[4]It is not clear where Keehn was working when he was injured, given that he stated his last employment ended in June 1995.

Dr. Moss diagnosed sciatica,[5] prescribed a Medrol DosePak[6] and Darvocet,[7] and scheduled a follow-up visit for seven to ten days. (R. 235) Keehn returned on September 16, 1996, for a refill of his Medrol DosePak, and noted some apparent improvement. (R. 234)

On November 1, 1996, Keehn saw L. J. Grobler, M.D., at the University of Iowa Hospitals and Clinics. (R. 262-63) Dr. Grobler took the following history:

> Glen A. Keehn is a 45 YOM who is an unemployed worker. He states that for the past 5-6 weeks, he has had [an] increasing amount of left-sided buttock pain, that extends into the left leg. He describes his sensation as being in the posterior thigh and calf and occasionally into the foot. He was seen by a Chiropractor on one occasion and then by his family physician, who took x-rays and prescribed Medrol dose Pak. He states no relief of his painful symptoms following the dose Pak. He is presently taking Tylenol with Codeine in the evening so that he can sleep. He has also had physical therapy treatment involving ultra-sound and electrical stimulation that were not beneficial. He has been off regular work for the past year, but has had no previous episodes of back or leg symptoms. He has worked at odd jobs during that time period. The most recent being last week driving a tractor. He denies any recent episodes of fever or chills, loss of bowel or bladder control, unexplained weight-loss or predominate night pain. He smokes 2 packs of cigarettes per day. Past medical history includes a MVA 13 years ago, that resulted in a left humerous [sic] fracture that was fixed with open reduction, internal fixation.

(R. 262) A physical examination was essentially normal. (*Id*.)

A lumbar MRI was ordered, and it showed the following:

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[5] Pain along the sciatic nerve. *Dorland's*, 1494.

[6] A packet of Medrol tablets. Medrol is a steroid used, among other things, "[a]s adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation)" in treating rheumatoid arthritis, sciatica, and other conditions. *See PDR*, 2621.

[7] "[I]ndicated for the relief of mild to moderate pain[.]" *PDR*, 1435.

> There is evidence of degenerative disc disease, most marked at L4-5 and L5-S1, associated with a left-sided paracentral disk bulge at L4-5 and a mild broad-based disc bulge at L5-S1. Neither of these disc bulges, however, appear to significantly impinge upon the exiting nerve roots. There is no significant apophyseal joint degenerative disease nor ligamentum hypertrophy, no neurofibromas are demonstrated in the cauda equina or lower-most portion of the spinal cord which ends at the level of L1-2. No prevertebral para-aortic mass is evident.

(R. 264) The conclusion of the radiologist from the MRI was "early degenerative disease as evidenced by disc desiccation and mild disc bulging, no evidence of neurofibromatosis." (*Id*.) Keehn was given an L4-5 epidural steroid injection. (R. 265)

Keehn saw Dr. Grobler for a follow-up visit about five weeks later, on December 4, 1996. (R. 266-67) Dr. Grobler concluded Keehn had "discogenic type symptoms," and noted his MRI was "largely unremarkable." (R. 266) Keehn said the epidural injection had given him only two days of relief, and otherwise, little had changed since his last visit. Keehn stated "his greatest problem is in the left buttock region, but he also will have problems down the posterior thigh and into the calf on the left." (*Id*.) Keehn told Dr. Grobler the symptoms increased when he was riding in a car or doing any extended sitting. (*Id*.)

Dr. Grobler observed the following on physical examination:

> Patient is initially favoring his left leg in gait and movement. Once he is up and about however this improves. He has slight difficulty walking on his heel on the left, but again this improved as he did the activity. Posture is significant for being locked at the knees, shifted forward at the hips and slightly shifted to the right. He had limitation in forward flexion initially verving [sic] off to the side and noting some posterior left lower extremity symptoms. This however improved with repetition. Extension had no affect [sic] on him. Other back movements were unremarkable.

(*Id*.) Dr. Grobler stated the following as his "Impression and Plan":

> Though the patient's baseline problem appears to be improving he does have some lingering sequela. He was instructed in a

> program of exercises to help begin activating him towards regular function. Specific program included postural adaption, rhythmic movement in both flexion and extension activities. Specific items included 7, 8, 91C and 96. He was also encouraged to [be] generally more active across the day. He will return in 4 weeks for further review of his situation. Necessary activity, modification and functional changes can be addressed at that time.

(*Id*.) There is no record that Keehn ever followed up at the University of Iowa Hospitals and Clinics.

On March 26, 1997, K. Andrew Crighton, M.D. performed a disability physical on Keehn for the Iowa Department of Disability Services ("DDS"). (R. 268-72) Dr. Crighton's assessment was that Keehn was suffering from "[c]hronic low back pain & left leg pain with no obvious lesion by MRI." (R. 270) He concluded as follows:

> [Keehn] should be able to lift from floor to waist approx. 30 pounds [and] from waist to shoulder level 50 pounds. This can be on a fairly frequent basis. Carrying would be limited to 50 pounds for no more than 20-30 feet at a time[.] Pt would better tolerate alternating standing & sitting position. Prolonged walking would probably aggravate his current condition. He would not be able to tolerate frequent stooping, kneeling or crawling. Pt's exam today does not reveal any abnormalities which would interfere with handling of objects, seeing, hearing, or speaking. Traveling would be limited to his ability to sit for prolonged period of time during driving. I do not see a problem with work environment unless it is extremely cold temperatures which may aggravate his current condition.

(*Id*.)

On April 24, 1997, a "Physical Residual Functional Capacity Assessment" was completed by Dennis A. Weis, M.D., a physician for DDS. (R. 273-80) According to Dr. Weis's assessment, Keehn could lift and/or carry twenty pounds occasionally and ten pounds frequently; stand and/or walk approximately six hours out of an eight-hour workday; sit,

with normal breaks, about six hours in an eight-hour workday; and push and/or pull, including operation of hand and/or foot controls, without limitation. (R. 274) According to Dr. Weis, Keehn occasionally could climb, stoop, kneel, crouch, and crawl. (R. 275) Dr. Weis determined that Keehn has no postural, manipulative, visual, communicative, or environmental limitations. (R. 275-77) Dr. Weis concluded Keehn's symptoms were attributable to a medically determinable impairment, but the severity and duration of his symptoms were disproportionate to what would be expected on the basis of Keehn's medically determinable impairments. (R. 278)

On July 25, 1997, Keehn saw Stephen D. Richards, D.O. at the Kossuth Regional Health Center "to talk about a SSI appeal." (R. 281) Dr. Richards took the following history:

> The pain is there all the time. He says he feels somewhat better when he first gets up and walks, but if he walks any distances at all it begins to get worse again. He cannot set [sic] for much over 15-20 minutes without having to get up and move around because it does get worse. He cannot drive a car as far as Fort Dodge without having to stop and get out and move around. He sleeps in a recliner chair. Has not been in a bed for about six months. He said that when he rolls side-to-side it feels worse. He describes one particular characteristic, he says that when he is driving the car down the street and he makes a left hand turn it feels worse.
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> * * *
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> He has also though noted that in the last couple weeks, his left shoulder is bothering him again. This is the shoulder where he had all the surgery back in 1983 from the car accident, and he has a plate and screws in there. He does not think there has been any new trauma to the shoulder, but it just hurts more. Unfortunately he does not have any money or insurance to cover him and so he does not want to take an x-ray. Obviuosly [sic] it probably should be done to see if there has been any loosening of the plate or screw in that left arm.

(*Id*.) Dr. Richards observed that Keehn walks with a limp, but was able to squat down and get back up from a deep knee bend, although he required some support to do so. (R. 282) He also

observed that Keehn was tender around his left shoulder. (*Id*.) He diagnosed Keehn as suffering from chronic leg pain and increased left shoulder pain. (*Id*.) Dr. Richards made the following conclusions and treatment recommendations:

> 1. As I told him, I thought it would be a good idea to get an x-ray of that left shoulder the way it is hurting. He will try to come up with some funding for this. 2. I suggested we try some Amitriptyline[8] 10 mg four times a day with two Tylenol 500 mg four times a day on a regular basis, not going any higher than that on medication, to see if that helps give him some pain improvement. 3. I encouraged him in his exercise program. 4. I certainly think that he has a years worth of discomfort that has been unresponsive to multiple therapies so he certainly has a disabling pain syndrome. I trulhy [sic] believe that he probably needs to be seen eventually at a voc rehab program and see what he might be retrainable in that allows him to control his work and days activity. I encouraged him to continue in his appeal process for the SSI as I think he is probably entitled to this.

(*Id*.)

Keehn next saw Dr. Richards almost eight months later, on March 17, 1998, with the same complaints. (R. 283) In his records, Dr. Richards noted "[t]he Amitriptyline helped a little, and at other times it didn't help." (*Id*.) He opined Keehn ultimately would need an orthopedic consult to deal with the tenderness he was having "right at the bottom portion of where that plate is at on the humerus . . . to see if the plate needs to be removed." (*Id*.) The doctor found no masses in Keehn's chest, and "[h]is chest sounds are otherwise clear." (*Id*.) He was still able to walk on his heels and toes, there were "no advancing neurologic findings," and Dr. Richards stated, "I don't think there is much more we can offer." (*Id*.) He recommended Keehn "continue to use the Tylenol instead of the orthopedic referral for the shoulder," and noted that if Keehn experienced weakness on heel and toe walking, he should

[8] Amitriptyline is "an antidepressant with sedative effects." *PDR*, 1758.

consider a repeat MRI "to make sure there is no new neurologic disease." (R. 283, 285) Keehn was advised to keep an eye on his blood pressure. (R. 285)

On July 28, 1998, Dr. Richards performed a "disability physical" for Keehn. (R. 286-90). Keehn's medications at that time were Voltaren XR,[9] Amitriptyline, and Extra-Strength Tylenol. (R. 286) Dr. Richards noted the following upon physical examination:

> He can walk on heels and toes. He can do a deep knee bend. He did not have any obvious restricted range of motion of the lumbar spine. . . . Essentially though, we mostly see a loss of abduction of the shoulder at being only about 100 degrees on the left. He is missing to about 30 degrees of forward elevation, being able to go to about 150 degrees on the left. No frank weakness of that arm is noted.

(R. 287-88) His assessment was chronic left low back and leg pain, and post open reduction and internal fixation of the left humeral fracture with chronic pain. (R. 288) In summation, Dr. Richards stated:

> This patient has now had a chronic left leg/low back pain syndrome since 1996. He has failed to respond to multiple conservative therapies. He therefore appears to have a chronic pain syndrome which probably will be indefinite. It significantly restricts his ability to function because the pain and discomfort extremely limits him with all activities. This includes a limited ability to walk, to sit, or lie for any prolonged periods of time. It also interferes with his ability to operate a motor vehicle and ride for prolonged periods of time.
>
> He appears to have no capability whatsoever of carrying out normal work activity, in that he is extremely limited in his ability to lift and carry in an eight hour work day or to stand, walk, move, or sit in an eight hour work day. He is able of [sic] stooping, climbing, kneeling [and] crawling but he can only do so for short periods of time before he has increased discomfort. He is able

[9] Voltaren is "a nonsteroidal anti-inflammatory drug." *PDR*, 861. It is not clear from the record which physician prescribed the Voltaren for Keehn.

> to handle objects, see, hear and speak but he has a limited ability to travel because of the pain syndrome. There are no work environments that he should necessarily avoid.
>
> It is my impression that he has a chronic pain syndrome which has little probability of improvement and he therefore appears to be totally disabled.

(*Id*.)

On August 16, 1998, Dr. Weis completed another "Physical Residual Functional Capacity Assessment" for Keehn. With one minor exception,[10] he reached the same conclusions he had reached on April 24, 1997. (R. 291-98) In an accompanying report dated August 6, 1998 (R. 299-300), Dr. Weis stated the following regarding Keehn's "consistency and credibility":

> The claimant did suffer an injury while lifting at work. He was originally seen by a chiropractor who could not provide much relief. He was referred to a medical doctor. He was referred ultimately to the U of Iowa Hospitals. They could find no surgical cause for his discomfort. He was treated with exercise programs, TENS unit, and medication. The claimant reports no response to these therapies. However, it is not supported in the medical evidence of records that the claimant followed through with treatments. He reported that he was not on medication for an extended time period, nor did he seek any medical treatment. The claimant reports that he is able to do dishes and laundry. He reports that he is able to mow the lawn and use a weed eater, he does take breaks while doing this activity. He reports that he does drive his car three or four times per day, short distances. He does grocery shopping and errands. He reports that he does light gardening. He reports that his day consists of watching television, reading, going for short walks, and doing minimal yard work. The claimant reports the ability to perform light daily activity. The claimant has not consistently sought medical treatment, and has not had x-rays taken as recommended by his

[10] He found one manipulative limitation, a restriction to light overhead reaching. (R. 294)

> doctor, this, at least to some degree erodes the claimant's credibility. Dr. Richards . . . reported (7/98) that the claimant "appears" to be disabled. However, exam findings do not support this degree of limitation, nor does the medical records history, and therefore, full weight cannot be given to his statement. This doctor also made statements in his report directly copied from his prior office notes (7/97), so it is difficult to know if this was again reported by the claimant, or taken from his history. Based on the medical evidence in file the claimant does have a medical response for the pain that he experiences. However, his remaining functional capacity, per his daily activities questionnaire and exam findings support a greater capacity for activity. The claimant's credibility is eroded to some degree, based on the evidence of record, the claimant's report of activity, his capacity to sustain work activity is restricted as indicated in the attached RFC.

(R. 300)

On October 17, 1998, Steven Gordon, a licensed psychologist, completed a psychological assessment of Keehn for DDS. (R. 304-306) Keehn advised Dr. Gordon he was on Voltaren and Elavil[11], which had been prescribed by Dr. Richards. (R. 304) He denied problems with alcohol or other drugs, but admitted drinking four or five beers a day. (*Id*.) The history taken by Dr. Gordon included the following:

> [Keehn] denies any mood swings or crying spells. He reports no problems with concentration, attention, or memory. He admits to some feelings of helplessness. Denies any hallucinations or delusional thinking. He denies any thoughts of wanting to harm himself or anyone else. When asked if he thought he was depressed, the client said he was every so often, especially when he realizes he can't go to work.

(R. 305) Dr. Gordon's diagnostic impression was "Adjustment Disorder With Depressed Mood; possible Alcohol Abuse." (R. 306)

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[11] A brand name for the drug Amitriptyline, defined in footnote 8, *supra*.

On October 19, 1998, Keehn saw Sant M. Hayreh, M.D. at the Neurology Department of the Mason City Clinic. (R. 301-303) Keehn told Dr. Hayreh that for fifteen years he has suffered from a dull, aching pain in his left arm, and for three years he has been bothered by pain in his lower back and left hip. (R. 301) The physical and neurological examinations were unremarkable, except Keehn appeared to smell of alcohol. (R. 302) Dr. Hayreh's impression was as follows:

> 1. Status post left humeral fracture with plate. The patient has chronic pain in the left arm which appears to be musculoskeletal in nature. Clinically, there is no evidence of any neuropathy.
> 2. Musculoskeletal type of low back pain and left hip pain. Clinically, again there is no evidence of any radiculopathy.
> 3. Suspect problem with alcohol abuse.
> 4. History of chronic smoking.

(R. 303)

On November 28, 1998, Jan Hunter, D.O. completed a medical consultant's form for Keehn.[12] (R. 307-308). Dr. Hunter concluded as follows:

> All things considered, despite the claimant's allegation of a worsening of his condition, physical exam is essentially unremarkable. The claimant's credibility is somewhat eroded by the fact he has not sought further medical intervention since the time of the last review although he did agree to attend the C/E. [B]y the claimant's own accord he is able to do dishes, able to do laundry, mow his lawn and use a weed eater. He reports he is able to do light gardening, watches TV, reads, goes for short walks. All things considered, the prior review dated 8-6-98 [by Dr. Weis] may be affirmed as written.

(R. 307)

On November 30, 1998, Philip R. Laughlin, Ph.D. completed a Psychiatric Review Technique Form. (R. 309-318) Dr. Laughlin found no evidence of an organic mental disorder;

[12] According to Keehn's attorney, Dr. Hunter never saw or examined Keehn. (R. 325)

schizophrenic, paranoid, or other psychotic disorder; mental retardation or autism; anxiety related disorder; somatoform disorder; or personality disorder. (R. 311-14) He did, however, find evidence of a "disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by . . . " an adjustment disorder and depressed mood. (R. 312) He also found questionable evidence of a substance addiction disorder. (R. 315) He rated the impairment from these disorders as "slight" with respect to daily living activities and social functioning, and concluded the disorders would seldom cause deficiencies of concentration, persistence, or pace that would result in the failure to complete tasks in a timely manner. (R. 316)

On April 30, 1999, Dr. Richards completed a "Physical Residual Functional Capacity Questionnaire." (R. 319-23) He opined that Keehn is incapable of performing even "low stress" jobs, he suffers from constant pain with any activity, and he is depressed by pain and his inability to work. (R. 320) He can sit for only twenty minutes or stand for only fifteen minutes before he is required to take a break to walk for ten minutes. (R. 321) If he works at a sedentary job, his legs must be elevated twenty percent of the time. (R. 322) He would require one unscheduled fifteen-minute break each hour. (R. 321) He can occasionally lift and carry up to twenty pounds, but can never lift and carry fifty pounds. (R. 322) He also is limited significantly in doing repetitive reaching, handling, and fingering. (*Id*.)

4. The ALJ's conclusions

The ALJ found Keehn has not engaged in substantial gainful activity since September 1, 1996, the date of his alleged disability (R. 22), and is unable to perform his past relevant work (R. 23). The ALJ concluded Keehn suffers from severe degenerative disc disease of the lumbar spine, with complaints of low back pain and leg pain; status post open reduction and internal fixation of the left humerus, with complaints of pain; hypertension; adjustment

disorder with depressed mood; and a history of neurofibromatosis.[13] (R. 23) According to the ALJ, Keehn does not have an impairment or combination of impairments listed in, or medically equal to, one listed in the Regulations. (R. 23)

The ALJ found the testimony of Keehn and his wife was credible regarding Keehn's functional restrictions, but found Keehn's contention that these restrictions preclude all work activity was not credible. (*Id*.) The ALJ found Keehn:

> has the residual functional capacity to perform the exertional and nonexertional requirements of work except for lifting more than 20 pounds occasionally or 10 pounds frequently. He cannot stand or sit more than one hour at a time, nor walk more than three to four blocks at a time. He cannot do repetitive bending, stooping, squatting, kneeling, crawling, or climbing. He cannot do repetitive overhead work with his left upper extremity. He cannot tolerate more than moderate conditions of vibration, and should avoid excessive cold. He cannot perform any job requiring very close attention to detail, or more than a regular pace.

(*Id*.)

The ALJ found Keehn "has acquired work skills, such as sales techniques and customer relations, which he demonstrated in past work, and which, considering his residual functional capacity, can be applied to meet the requirements of semi-skilled work functions of other work." (R. 24) The ALJ concluded, "considering the claimant's age, education, previous work experience, and residual functional capacity, jobs still exist in significant numbers in the national economy that he can perform." (*Id*.) Accordingly, the ALJ found Keehn was not under a disability as defined by the Social Security Act at any time through the date of the decision. (*Id*.)

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[13] "Neurofibromatosis," also known as von Recklinghausen's Disease, is a genetic disorder of the nervous system "that primarily affect[s] the development and growth of neural (nerve) cell tissues." The disorder "cause[s] tumors to grow on nerves and produce other abnormalities such as skin changes and bone deformities." National Institute of Neurological Disorders and Stroke, Neurofibromatosis Information Page, www.ninds.nih.gov/health_and_medical/disorders/neurofibro.htm (visited 03/23/01).

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering . . . his age, education and work experience, engage in any other kind of substantial gainful work which exists in [significant numbers in] the national economy . . . either in the region in which such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley*, 133 F.3d at 587-88 (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy

that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id*.; *Hunt v. Heckler*, 748 F.2d 478, 479-80 (8th Cir. 1984) ("[O]nce the claimant has shown a disability that prevents him from returning to his previous line of work, the burden shifts to the ALJ to show that there is other work in the national economy that he could perform.") (citing *Baugus v. Secretary of Health & Human Serv.*, 717 F.2d 443, 445-46 (8th Cir. 1983); *Nettles v. Schweiker*, 714 F.2d 833, 835-36 (8th Cir. 1983); *O'Leary v. Schweiker*, 710 F.2d 1334, 1337 (8th Cir. 1983)).

Step five requires that the Commissioner bear the burden on two particular matters:

> In our circuit it is well settled law that once a claimant demonstrates that he or he is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

Nevland v. Apfel, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added) *accord Weiler*, 179 F.3d at 1110 (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Weiler v. Apfel*,

179 F.3d 1107, 1109 (8th Cir. 1999) (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley v. Callahan*, 133 F.3d 583, 587 (8th Cir. 1998) (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, substantial evidence means something "less than a preponderance" of the evidence, *Kelley*, 133 F.3d at 587, but "more than a mere scintilla," *Richardson v. Perales*, 402 U.S. 389, 401, 91 S. Ct. 1420, 1427, 28 L. Ed. 2d 842 (1971); *accord Ellison v. Sullivan*, 921 F.2d 816, 818 (8th Cir. 1990). Substantial evidence is "relevant evidence which a reasonable mind would accept as adequate to support the [ALJ's] conclusion." *Weiler*, 179 F.3d at 1109 (again citing *Pierce*, 173 F.3d at 706); *Perales*, 402 U.S. at 401, 91 S. Ct. at 1427; *accord Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993); *Ellison*, 91 F.2d at 818.

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account "'whatever in the record fairly detracts from'" the weight of the ALJ's decision. *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *accord Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213). Thus, the review must be "more than an examination of the record for the existence of substantial evidence in support of the Commissioner's decision"; it must "also take into account whatever in the record fairly detracts from the decision." *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Gavin v. Heckler*, 811 F.2d 1195, 1199 (8th Cir. 1987)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22

F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992) (citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently," *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)), because the court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.*, 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen*, 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.*, 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*, 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). Under *Polaski:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

1) the claimant's daily activities;
2) the duration, frequency and intensity of the pain;
3) precipitating and aggravating factors;
4) dosage, effectiveness and side effects of medication;
5) functional restrictions.

Polaski, 739 F.2d at 1322.

IV. ANALYSIS

After the ALJ found Keehn to be unable to perform his past relevant work, he decided this case under step five of the five-step process outlined in the regulations. Under step five, the Commissioner bears the burden of proving the claimant retains the residual functional capacity to work, and work exists in substantial numbers in the national economy that the claimant is able to do. The ALJ found the Commissioner had met this burden. The court now must determine whether substantial evidence in the record as a whole supports the ALJ's decision.

In the ALJ's first hypothetical question, he described a hypothetical male with impairments approximating those afflicting Keehn, and asked the VE if the hypothetical person would be able to perform jobs in the national economy. The VE responded that the person described in the question would be able to perform jobs available in the national economy. In response to the second and third hypothetical questions posed by the ALJ, and in response to two additional hypothetical questions posed by Keehn's attorney, the VE responded that the person describe in those questions would be precluded from all competitive employment. To decide this case, the court must determine whether substantial evidence in the record as a whole supports a conclusion that the ALJ's first hypothetical question accurately reflected Keehn's impairments, while the additional impairments in the other four hypothetical questions do not accurately reflect those impairments. The denial of benefits to Keehn can

be sustained only if the ALJ's first hypothetical question was the only valid hypothetical question out of the five hypothetical questions posed to the VE at the hearing.

The Eighth Circuit has held an ALJ's hypothetical question must fully describe the claimant's abilities and impairments as evidenced in the record. *See Chamberlain v. Shalala*, 47 F.3d 1489, 1495 (8th Cir. 1995) (citing *Shelltrack v. Sullivan*, 938 F.2d 894, 898 (8th Cir. 1991)). A hypothetical question is "sufficient if it sets forth the impairments which are accepted as true by the ALJ." *Johnson v. Chater*, 108 F.3d 178, 180 (8th Cir. 1997); *House v. Shalala*, 34 F.3d 691, 694 (8th Cir. 1994). Only the impairments substantially supported by the record as a whole must be included in the ALJ's hypothetical. *Cruze v. Chater*, 85 F.3d 1320, 1323 (8th Cir. 1996) (citing *Stout v. Shalala*, 988 F.2d 853, 855 (8th Cir. 1993)). If a hypothetical question does not encompass all relevant impairments, the vocational expert's testimony does not constitute substantial evidence to support the ALJ's finding of no disability. *Cruze*, 85 F.3d at 1323 (citing *Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994)). The ALJ may produce evidence of suitable jobs by eliciting testimony from a VE "concerning availability of jobs which a person with the claimant's particular residual functional capacity can perform." *Cox v. Apfel*, 160 F.3d 1203, 1207 (8th Cir. 1998). A "proper hypothetical question presents to the vocational expert a set of limitations that mirror those of the claimant." *Hutton v. Apfel*, 175 F.3d 651, 656 (9th Cir. 1999).

In *Wiekamp v. Apfel*, 116 F. Supp. 2d 1056 (N.D. Iowa 2000), Chief Judge Mark W. Bennett explained further the requirements for a proper hypothetical question posed to a VE:

> "Testimony from a vocational expert is substantial evidence only when the testimony is based on a correctly phrased hypothetical question that captures the concrete consequences of a claimant's deficiencies." *Taylor v. Chater*, 118 F.3d 1274, 1278 (8th Cir. 1997). Although "questions posed to vocational experts should precisely set out the claimant's particular physical and mental impairments, . . . a proper hypothetical question is

> sufficient if it sets forth the impairments which are accepted as true by the ALJ." *House v. Shalala*, 34 F.3d 691, 694 (8th Cir. 1994) (internal citations, quotation marks, and alterations omitted).
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> *Roberts v. Apfel*, 222 F.3d 466, 471 (8th Cir. 2000). "The hypothetical need not use specific diagnostic terms . . . where other descriptive terms adequately describe the claimant's impairments." *Warburton* [*v. Apfel*], 188 F.3d [1047,] 1050 [(8th Cir. 1999)]. An ALJ is not required to include in a hypothetical question to a vocational expert any impairments that are not supported by the record. *Prosch*, 201 F.3d at 1015. However, where an ALJ improperly rejects the opinion of a treating physician or subjective complaints of pain by the claimant, the vocational expert's testimony that jobs exist for the claimant does not constitute substantial evidence on the record as a whole where the vocational expert's testimony does not reflect the improperly rejected evidence. *See Singh*, 222 F.3d at 453 ("In view of our findings that the ALJ improperly rejected both the opinion of Singh's treating physician and Singh's subjective complaints of pain, we find that the hypothetical question posed to the vocational expert did not adequately reflect Singh's impairments. Accordingly, the testimony of the vocational expert that jobs exist for Singh cannot constitute substantial evidence on the record as a whole.").

Wiekamp, 116 F. Supp. 2d at 1073-74.

The question in this appeal, therefore, boils down to whether there is substantial evidence in the record to support a finding that Keehn does not suffer from any of the additional impairments included in the ALJ's second or third hypothetical questions or in the claimant's two hypothetical questions. These alleged additional impairments are as follows: (1) Keehn cannot sit for more than fifteen to twenty minutes at a time or stand for more than twenty minutes at a time;[14] (2) he needs to take unscheduled work breaks with his feet elevated

[14] *See* the ALJ's second hypothetical question at R. 77-78.

higher than his head, and ten-minute periods of walking every twenty minutes during an eight-hour day;[15] (3) he can work only at a slow pace, and not at a regular pace;[16] and (4) constant pain adversely affects his ability to maintain concentration and attention for extended periods of time.[17] If the ALJ's finding that Keehn does not suffer from any of these additional impairments is supported by substantial evidence in the record as a whole, then Keehn is not entitled to disability benefits. Otherwise, he is entitled to disability benefits.

The evidence in the record supporting the impairments added in the ALJ's second and third hypothetical questions consists of the testimony of Keehn and his wife and the records and reports of Dr. Richards. That evidence can be summarized as follows:

C ***Testimony of Keehn and His Wife***

Keehn testified he cannot hold a job because of low back, arm, and chest pain. (R. 50) According to Keehn, to alleviate his pain, he must alternate regularly between sitting, standing, and walking. (R. 53-54) He also testified he can stand for only twenty minutes at a time. (R. 65) Keehn's wife testified her husband has constant pain on his left side in his arm, leg, and hip, and is unable to sit for long periods of time. (R. 69-70)

C ***Records and Reports of Dr. Richards***

In the records of Dr. Richards's first office visit with Keehn, on July 25, 1997, initiated by Keehn "to talk about a SSI appeal" (R. 281), Dr. Richards found Keehn has "a disabling pain syndrome." (R. 282) In a report of a "disability physical" prepared on July 28, 1998, about a year later, Dr. Richards noted Keehn "appears to have a chronic pain syndrome which

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[15] *See* the ALJ's third hypothetical question at R. 78-79.

[16] *See* Keehn's attorney's first hypothetical question at R. 80-81.

[17] *See* Keehn's attorney's second hypothetical question at R. 80-81.

probably will be indefinite." (R. 288) According to Dr. Richards, this syndrome "significantly restricts [Keehn's] ability to function because the pain and discomfort extremely limits him with all activities. This includes a limited ability to walk, to sit, or lie for any prolonged periods of time." (*Id*.) Dr. Richards also observed Keehn "appears to have no capability whatsoever of carrying out normal work activity, in that he is extremely limited in his ability to . . . walk, move, or sit in an eight hour work day." (*Id*.) Dr. Richards concluded Keehn "has chronic pain syndrome which has little probability of improvement and he therefore appears to be totally disabled." (*Id*.) On April 30, 1999, Dr. Richards completed a "Physical Residual Functional Capacity Questionnaire" in support of Keehn's application for disability insurance benefits. (R. 319-23) In the questionnaire, Dr. Richards stated Keehn is incapable of performing even "low stress" jobs (R. 320); he suffers from constant pain with any activity (*Id*.); he can sit only for twenty minutes or stand for only fifteen minutes before taking a ten-minute break to walk (R. 321); and if he were to work at a sedentary job, his legs would have to be elevated twenty percent of the time (R. 322), and he would require one unscheduled break for fifteen minutes each hour before returning to work (R. 321).

If the ALJ had accepted this evidence, there would have been substantial evidence in the record to support a finding that Keehn was disabled. However, the ALJ decided this evidence had little weight, and chose to accept other, contradictory evidence. The court must determine whether this was error.

The evidence in the record supporting the impairments added in Keehn's attorney's first and second hypothetical questions consists of two statements from the October 17, 1998, report of psychologist Dr. Gordon: "Pace may be slow because of the pain experienced," and "the pain experienced may adversely affect the client's ability to maintain attention and

concentration for extended periods of time." (R. 305) Again, the ALJ gave this evidence little weight, and the court must determine whether this was error.[18]

A. The Testimony of Keehn and His Wife

Keehn claims the additional impairments in the ALJ's second and third hypotheticals, and in the two hypotheticals posed by his attorney, are supported by his testimony and the testimony of his wife, and he argues the ALJ improperly evaluated, and then rejected, that testimony. The Commissioner responds that the ALJ properly rejected this testimony.

In his decision, the ALJ recognized his burden to give full consideration to all the evidence presented, citing *Polaski*, but did not set forth his step-by-step analysis of the *Polaski* factors. (R. 19-21) The court finds that although the ALJ did not set out each of the *Polaski* factors in individual paragraphs, he discussed the evidence in light of those requirements, and this was satisfactory. *See Lowe v. Apfel*, 226 F.3d 969, 972 (8th Cir. 2000) (ALJ was not required to discuss methodically each *Polaski* consideration, so long as he acknowledged and examined those considerations before discounting the claimant's subjective complaints.)

The ALJ described Keehn's daily activities,[19] and then concluded, "the claimant's activities of daily living indicate that he is capable of a much higher level of functioning than he alleges." (R. 21) This conclusion appears to be based on Dr. Weis's assessment of August

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[18]Keehn also argues his claim of disability is supported by evidence that he suffers from depression. However, although the record indicates Keehn has been on low-dose antidepressants since at least March of 1998 (*see* text accompanying footnote 8, *supra*), the record indicates Keehn sometimes feels depressed because he is not working (R. 66, 305, 320), not that he cannot work because he is depressed. In any event, the evidence in the record is that any impairment from depression is "slight." (R. 315) There is no evidence that any depression suffered by Keehn is disabling. *See Trenary v. Bowen*, 898 F.2d 1361, 1364 (8th Cir. 1990) (depression is not necessarily disabling).

[19]"[H]e says his day begins at approximately 6:30 a.m., and he will watch television until noon. He does help with housework and in the evening watches a TV movie or picks up around the house. He does not nap during the day." (R. 20)

1998, when the doctor noted Keehn reported he was able to mow the lawn and use a weed eater, taking breaks while doing so. He could "drive his car three or four times per day, short distances," go grocery shopping, run errands, and engage in light gardening. At that time, Keen reported his typical day "consists of watching television, reading, going for short walks, and doing minimal yard work," as well as performing light daily activities. (R. 300)

However, Dr. Weis's report was completed some nine months prior to the hearing, at which Keehn testified he no longer goes for walks or mows the lawn, and it is painful for him to drive a car. (R. 52-53) The ALJ specifically found Keehn's testimony regarding his functional restrictions to be credible. (R. 23) The ALJ, however, disagreed with Keehn's contention that his functional restrictions precluded him from all work activity. (*Id.*)

Just because Keehn is able to engage in some of the normal activities of daily life "does not qualify as the ability to do substantial gainful activity." *Thomas v. Sullivan*, 876 F.2d 666, 669 (8th Cir. 1989); *Easter v. Bowen*, 867 F.2d 1128, 1130 (8th Cir. 1989). A claimant is entitled to continued enjoyment of life, despite a disability. Indeed, "an SSI claimant need not prove that [he or] she is bedridden or completely helpless to be found disabled." *Cline v. Sullivan*, 939 F.2d 560, 566 (8th Cir. 1991) (citing *Thomas, supra*).

The uncontroverted evidence in the record is that Keehn suffers from constant pain. Keehn's claim of constant pain is supported not only by his own testimony, but also by his wife's testimony, and by the medical records from all of the physicians who have treated Keehn since the alleged onset date of his disability. The only dispute seems to relate to the intensity of the pain, and the extent to which it would prevent Keehn from working. *Cf. Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997) ("As is true in many disability cases, there is no doubt that the claimant is experiencing pain; the real issue is how severe that pain is."); *Pickner v. Sullivan*, 985 F.2d 401, 404 (8th Cir. 1993) (The question is not whether the claimant experiences pain, "but whether to fully believe [his] claim that those subjective

complaints prevented [him] from performing sedentary or light work." Citing *Russell v. Sullivan*, 950 F.2d 542, 545 (8th Cir. 1991)).

Keehn stated his pain is aggravated by lifting, sitting, standing, or walking for more than a short period of time, and by riding in an automobile. He testified his pain prevents him from engaging in anything more than minimal activities of daily living. However, the record shows, as the ALJ noted, that Keehn "used only over-the-counter medications for the first several years after his alleged disability onset, and indicates that even now he uses his prescribed pain medications only sparingly. This [ ] indicates that the claimant's pain is of at least a tolerable level." (R. 21) *See Rankin v. Apfel*, 195 F.3d 427, 429 (8th Cir. 1999). The ALJ discounted Keehn's subjective complaints because they were "inconsistent with the objective medical evidence and [his] relatively normal daily functions[.]" *Pickner, supra*.

In addition, the ALJ pointed out that Keehn did not seek medical treatment during much of the period after the alleged onset date of his disability. (R. 21) Keehn responds that he did not have funds to pay for additional medical treatment, and that he had been advised by doctors that additional medical treatment would do nothing to alleviate his pain. The court finds this factor weighs against Keehn's credibility. Instead of continuing to smoke two packs of cigarettes a day and drink four to five beers a day, Keehn could have saved money for medical care. *See Riggins v. Apfel*, 177 F.3d 689 (8th Cir. 1999) (claimant's three-pack-a-day cigarette habit mitigated against his claims that he could not afford health care); *see also Meeks v. Apfel*, 993 F. Supp. 1265, 1276 (W.D. Mo. 1997) (citing *Roth v. Shalala*, 45 F.3d 279, 282 (8th Cir. 1995)) (The failure to follow a prescribed course of remedial treatment without good reason is grounds for denying an application for benefits.)

Although Keehn's long work history supports his credibility, considering the record as a whole, the court finds substantial evidence supports the ALJ's decision to discount the testimony of Keehn and his wife concerning the disabling nature of the pain suffered by Keehn.

B. Evaluating the Medical Evidence

Keehn claims the ALJ erred when he rejected the opinions of Dr. Richards, Keehn's treating physician, and accepted other medical evidence. The ALJ reached the following conclusions concerning Dr. Richards's opinions:

> Dr. Richards' objective findings do not substantiate his opinions regarding the claimant's functional capacity. By his own findings, the claimant had no limitations in any range of motion, and the claimant's neurological examination was "unremarkable." He did find positive straight-leg raising at about 65 degrees on the left, but the claimant could heel and toe walk, as well as do deep knee bends. He did note some loss of abduction in the left shoulder, though no frank weakness of that arm was noted. . . . Dr. Richards' opinions subsequent to his July 1998 evaluation of the claimant are given little weight for the same reasons as noted above, as well as the fact that they are not consistent with his own objective findings.

(R. 17-18) Keehn argues the ALJ improperly rejected the opinion of a treating physician in favor of other, non-treating physicians.

In *Prosch v. Apfel*, 201 F.3d 1010 (8th Cir. 2000), the Eighth Circuit Court of Appeals discussed the weight to be given to the opinions of treating physicians:

> The opinion of a treating physician is accorded special deference under the social security regulations. The regulations provide that a treating physician's opinion regarding an applicant's impairment will be granted "controlling weight," provided the opinion is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record." 20 C.F.R. § 404.1527(d)(2). Consistent with the regulations, we have stated that a treating physician's opinion is "normally entitled to great weight," *Rankin v. Apfel*, 195 F.3d 427, 430 (8th Cir. 1999), but we have also cautioned that such an opinion "do[es] not automatically control, since the record must be evaluated as a whole." *Bentley v. Shalala*, 52 F.3d 784, 785-86 (8th Cir. 1995). Accordingly, we have upheld an ALJ's decision to

> discount or even disregard the opinion of a treating physician where other medical assessments "are supported by better or more thorough medical evidence," *Rogers v. Chater*, 118 F.3d 600, 602 (8th Cir. 1997), or where a treating physician renders inconsistent opinions that undermine the credibility of such opinions, *see Cruze v. Chater*, 85 F.3d 1320, 1324-25 (8th Cir. 1996).
>
> Whether the ALJ grants a treating physician's opinion substantial or little weight, the regulations provide that the ALJ must "always give good reasons" for the particular weight given to a treating physician's evaluation. 20 C.F.R. § 404.1527(d)(2);*see also* SSR 96-2p.

Prosch, 201 F.3d at 1012-13

As Judge Mark W. Bennett of this court recently observed in considering the weight to be given treating physicians' opinions:

> The importance of the opinions of treating physicians in the determination of disability is well-settled:
>
> > A treating physician's opinion should not ordinarily be disregarded and is entitled to substantial weight. *See Ghant v. Bowen*, 930 F.2d 633, 639 (8th Cir. 1991). A treating physician's opinion regarding an applicant's impairment will be granted controlling weight, provided the opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record. *See Kelley v. Callahan*, 133 F.3d 583, 589 (8th Cir. 1998). By contrast, "[t]he opinion of a consulting physician who examines a claimant once or not at all does not generally constitute substantial evidence." *Id*. Likewise, the testimony of a vocational expert who responds to a hypothetical based on such evidence is not substantial evidence upon which to base a denial of benefits. *See Nevland* [*v. Apfel*], 204 F.3d [853,] 858 [(8th Cir. 2000)].

> * * *
>
> [When t]here is no evidence in the record to support the ALJ's residual functional capacity finding other than the non-treating physicians' assessments . . . [t]hese assessments alone cannot be considered substantial evidence in the face of the conflicting assessment of a treating physician. *See Henderson v. Sullivan*, 930 F.2d 19, 21 (8th Cir. 1991).
>
> * * *
>
> The Commissioner is encouraged to give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist. *See Metz v. Shalala*, 49 F.3d 374, 377 (8th Cir. 1995). In any event, whether the ALJ grants a treating physician's opinion substantial or little weight, the regulations also provide that the ALJ must "always give good reasons" for the particular weight given to a treating physician's evaluation. 20 C.F.R. § 404.1527(d)(2).

Singh [*v. Apfel*], 222 F.3d [448,] 452 [(8th Cir 2000)] (emphasis added); (other citation omitted).

* * *

In *Singh[ ]*, where the court found that "[t]he record here is replete with evidence that substantiates the opinion of Singh's treating physician," the only contrary evidence was the opinions of non-treating physicians, and the treating physician was a specialist, the court held that the ALJ had improperly disregarded the conclusions of the claimant's treating physician. *Singh*, 222 F.3d at 452. Similarly, in *Cunningham v. Apfel*, 222 F.3d 496 (8th Cir. 2000), the Eighth Circuit Court of Appeals concluded that, if the ALJ had properly credited the opinions of treating physicians, the evidence would have supported a conclusion that the claimant was presumptively disabled, either by diabetes, neuropathy, or mental illness, or that the claimant, at the very

> least, had combined impairments that mandated a finding that the claimant could not return to her former job. *Cunningham*, 222 F.3d at 502."

Wiekamp, 116 F. Supp. 2d at 1063-64.

Before reaching the question of whether the ALJ gave the proper weight to Dr. Richards's opinions, a threshold question is whether Dr. Richards was, in fact, a "treating physician." Both the ALJ and Keehn seem to assume he is; however, the record indicates otherwise. From at least 1988, through September 16, 1996, about two weeks after the alleged onset date of his disability, Keehn's regular treating physician was Dr. Moss of the Kossuth Regional Health Center. Keehn first saw Dr. Richards, also from the Kossuth Regional Health Center, on July 25, 1997. The purpose of the visit was "to talk about a SSI appeal," apparently in response to the unfavorable disability physical performed by Dr. Crighton on March 26, 1997, and the equally unfavorable assessment completed by Dr. Weis on April 24, 1997. From the record, it appears that after the July 25, 1997, consultation "to talk about a SSI appeal," Keehn actually only saw Dr. Richards two other times, on March 17, 1998, and on July 28, 1998, for a disability physical. The record indicates the only actual treatment rendered by Dr. Richards was to prescribe Amitriptyline and Tylenol, and to make several recommendations which do not appear to have been followed by Keehn.[20]

A "treating physician" is a physician who has "treated the claimant/patient over a number of years." *Kirk v. Secretary*, 667 F.2d 524, 536 (6th Cir. 1981), *cert. denied*, 461 U.S. 957

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[20]Dr. Richards recommended Keehn get an x-ray of his shoulder, engage in an exercise program, look into vocational rehabilitation to investigate retraining in another type of job, consider a repeat MRI if he continued to have problems, and watch his blood pressure. (R. 283, 285) The record does not indicate Keehn followed any of these recommendations. In addition, Keehn was cautioned about his two-pack-a-day smoking habit on December 3, 1990, in a DOT physical. (R. 239) Nevertheless, when he saw Dr. Grobler some six years later, on November 1, 1996, he was still smoking two packs per day. (R. 262) On October 19, 1998, Dr. Hayreh noted Keehn had a "[h]istory of chronic smoking." (R. 303) The record tends to indicate Keehn has been largely noncompliant with physicians' recommendations that could have improved his health and daily life.

(1983); *see Campbell v. Bowen*, 800 F.2d 1247, 1250 (4th Cir. 1986) ("[T]he opinion of a treating physician is entitled [to] more weight because it reflects a judgment based on a continuing observation over a number of years."); *Mitchell v. Schweiker*, 699 F.2d 185, 187 (4th Cir. 1983) ("While the Secretary is not bound by the opinion of a claimant's treating physician, that opinion is entitled to great weight for it reflects an expert judgment based on a continuing observation of the patient's condition over a prolonged period of time.") To determine whether a physician is a "treating physician," the court must consider the length of the treatment relationship, the frequency of examination, and the nature and extent of the treatment relationship. *See* 20 C.F.R. § 404.1527(d)(2)(i) & (ii); *Henderson v. Sullivan*, 930 F.2d 19, 21 (8th Cir. 1991) ("We have consistently discounted the opinions of non-treating physicians who have seen the patient only once, at the request of the Social Security Administration. There is no reason to treat differently the opinion of a non-treating physician who has seen the patient only once, at the request of the patient or her lawyer.").

A physician will be regarded as a "treating physician" only if the physician has seen the patient "a number of times and long enough to obtain a longitudinal picture of [the patient's] impairment." 20 C.F.R. § 404.1527(d)(2)(i); *see, e.g.*, *Trossauer v. Chater*, 121 F.3d 341, 344 (8th Cir. 1997) (Doctor "could be expected to be quite familiar with the medical history of a patient he had treated for almost forty years.") On the record in this case, Dr. Richards was not a treating physician. His opinions must be evaluated and given the weight of other non-treating physicians, and his opinions are directly contradicted by the opinions of nearly all of the other physicians who examined or evaluated Keehn.

Keehn saw Dr. Grobler at the University of Iowa Hospitals and Clinics on November 1, 1996. A lumbar MRI ordered by Dr. Grobler showed evidence of early degenerative disease. Keehn also was given an L4-5 epidural steroid injection and released. Keehn saw Dr. Grobler for a follow-up visit about five weeks later, on December 4, 1996, and Dr. Grobler concluded Keehn has "discogenic type symptoms," but noted the MRI was "largely unremarkable." (R.

266) On physical examination, Dr. Grobler observed Keehn initially favored his left leg in gait and movement, but once he was up and about, this improved. Keehn had slight difficulty walking on his heel on the left, but again this improved with activity. Keehn initially had limitation in forward flexion with some posterior left lower extremity symptoms, but this too improved with repetition. He was not bothered by extension, and his other back movements were unremarkable. Dr. Grobler stated the following, in part, in the "Impression and Plan"segment of his report:

> Though the patient's baseline problem appears to be improving he does have some lingering sequela. He was instructed in a program of exercises to help begin activating him towards regular function. . . . He was also encouraged to [be] generally more active across the day. He will return in 4 weeks for further review of his situation. Necessary activity, modification and functional changes can be addressed at that time.

(R. 266) Keene did not return in four weeks as directed.

On March 26, 1997, Dr. Crighton performed a disability physical for the Iowa DDS. (R. 268-72) His assessment was that Keehn was suffering from "[c]hronic low back pain & left leg pain with no obvious lesion by MRI." (R. 270) He concluded Keehn should, on a frequent basis, be able to lift approximately thirty pounds from floor to waist, and approximately fifty pounds from waist to shoulder level. He should be able to carry up to fifty pounds for no more than twenty to thirty feet at a time He would better tolerate alternating standing and sitting. Prolonged walking would probably aggravate his condition. He would not be able to tolerate frequent stooping, kneeling, or crawling. He has no abnormalities that would interfere with handling of objects, seeing, hearing, or speaking. He would have no problem with any work environment except for cold temperatures, which might aggravate his condition.

On April 24, 1997, a "Physical Residual Functional Capacity Assessment" was completed by Dr. Weis, a physician for DDS. According to Dr. Weis's assessment, Keehn

could lift or carry twenty pounds occasionally and ten pounds frequently; stand or walk approximately six hours out of an eight-hour workday; sit, with normal breaks, about six hours in an eight-hour workday; and push or pull, including operation of hand and foot controls, without limitation. Keehn occasionally could climb, stoop, kneel, crouch, and crawl. Keehn had no postural, manipulative, visual, communicative, or environmental limitations. Dr. Weis concluded that the severity and duration of Keehn's symptoms were disproportionate to what would be expected from Keehn's medically determinable impairments.

On August 16, 1998, Dr. Weis completed a second "Physical Residual Functional Capacity Assessment" for Keehn, and reached essentially the same conclusions he had reached on April 24, 1997. In an accompanying report, Dr. Weis stated that the medical records and examination findings did not support the degree of limitation claimed by Keehn, and therefore, full weight should not be given to his claims.

On October 19, 1998, Keehn saw Dr. Hayreh at the Neurology Department of the Mason City Clinic. Dr. Hayreh's physical and neurological examinations were unremarkable, except Keehn appeared to smell of alcohol. Dr. Hayreh noted Keehn had chronic pain in his left arm, with no evidence of neuropathy; low back and left hip pain, with no evidence of radiculopathy; a history of chronic smoking; and a suspected problem with alcohol abuse. (R. 303)

On November 28, 1998, Dr. Hunter completed a medical consultant's form. From reviewing Keehn's records, Dr. Hunter concluded that despite Keehn's allegation that his condition was worsening, his physical examination was essentially unremarkable. Dr. Hunter felt Keehn's credibility was called into question by the fact he had not sought further medical intervention since the time of his last review.

This body of evidence substantially supports the ALJ's decision to discredit Dr. Richards's opinions. Furthermore, Dr. Richards's opinions were based largely on Keehn's subjective complaints. When a physician's conclusion is based heavily on the claimant's

subjective complaints and is at odds with the weight of the objective evidence, including the claimant's daily activities and physical therapy records, the physician's opinion properly may not be afforded the same degree of deference. *Rankin, supra*, 195 F.3d at 429 (citing *Haggard v. Apfel*, 175 F.3d 591, 595 (8th Cir. 1999)). Moreover, an ALJ is not required to adopt the opinion of a physician on the ultimate issue of a claimant's disability. 20 C.F.R. § 416.927(e)(1); *Sampson v. Apfel*, 165 F.3d 616, 618 (8th Cir. 1999) The court finds the ALJ decision to discount the opinions of Dr. Richards is supported by the record.

Keehn also argues the opinions from the October 17, 1998, report of psychologist Dr. Gordon were ignored by the ALJ without justification. Those opinions consist of the following two statements: "Pace may be slow because of the pain experienced," and "the pain experienced may adversely affect the client's ability to maintain attention and concentration for extended periods of time." (R. 305) These phrases are taken from the following paragraph, in which Dr. Gordon summarizes Keehn's "Work Related Activities":

> Mr. Keehn has the ability to remember simple as well as more complex details, locations, and work-like procedures. However, the pain experienced may adversely affect the client's ability to maintain attention and concentration for extended periods of time. He has the ability to sustain an ordinary routine without special supervision and make simple work-related decisions. He should be able to interact appropriately with the general public and get along with coworkers and supervisors. He should be able to respond appropriately to changes in the work setting. Pace may be slow because of the pain experienced. Judgment appears adequate. He should be able to handle cash benefits at this time.

(*Id*.)

Keehn argues the first statement, "Pace may be slow because of the pain experienced," is equivalent to, "a slow pace throughout a week day and a work week."[21] The court disagrees.

[21]In the first hypothetical question posed to the VE by Keehn's attorney, he added this restriction to the ALJ's first hypothetical question, and the VE found a person with this additional restriction would be

Dr. Gordon's statement was that Keehn's pace *may* be slow, implying either (1) his pace of work might be slow or it might not be slow, or (2) his pace of work will be slow at certain times but not at other times. Dr. Gordon did not express an opinion that Keehn's pace of work would always be slow, as stated by Keehn's attorney in his hypothetical question.

Keehn also argues the second statement, "the pain experienced may adversely affect the client's ability to maintain attention and concentration for extended periods of time," is equivalent to "constant pain adversely affects his ability to maintain concentration and attention for extended periods of time."[22] The court again disagrees, and for the same reason. Dr.

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precluded from all competitive employment. The actual exchange was as follows:

> Q Mr. Johnson, if we go back to the Judge's first hypothetical, and would you like me to go through that again, or do you recall what it is?
>
> A No. I recall what it is.
>
> Q Exhibit, if, if you add in a factor of slow pace as opposed to, I think there was a reasonable pace in the first hypothetical, so if you change that point, would that change your opinion with respect to that hypothetical?
>
> A Yes, it would. It would preclude such employment.
>
> Q Would there be other jobs that would be available under that hypothetical?
>
> A Are we looking at a slow pace at all times?
>
> Q Well, what I was getting that from is there's a psychological assessment that's indicated at 11F, and the psychologist who did that indicates in that, and I'm quoting, pace may be slow because of the pain experienced. So, I guess based on the hypothetical that, that there would be constart [sic] slow pace throughout a week day and a work week.
>
> A Again, that would preclude the telephone sales, yes.

(R. 80-81)

[22] In the second hypothetical question posed to the VE by Keehn's attorney, he added this restriction to the ALJ's first hypothetical question, and the VE again found a person with this additional restriction would be precluded from all competitive employment. The actual exchange was as follows:

> Q If we again go back to the Judge's first hypothetical, but this time add in a factor that constant pain adversely affects claimant's ability to maintain concentration and attention for extended periods of time, does that change your, your first initial opinion?
>
> A I see very little difference between the slow pace and the limitation you're describing right now.

(R. 81)

Gordon's statement was that Keehn's pain *may* affect his ability to pay attention and concentrate, implying either (1) pain might affect his ability to pay attention and concentrate, or it might not, or (2) pain might affect his ability to pay attention and concentrate at certain times but not at other times. Dr. Gordon did not express an opinion that Keehn's ability to pay attention and concentrate would always be adversely affected by pain, as stated by Keehn's attorney in his hypothetical question.

Furthermore, the opinions of Dr. Gordon, as construed by Keehn, are in conflict with the opinions of Drs. Crighton, Weis, Hunter, and Laughlin. The ALJ chose to accept the opinions of these other medical professionals rather than crediting Dr. Gordon's opinions. The ALJ may "weigh evidence and make judgments as to what evidence is most persuasive." *Stephens v. Heckler*, 766 F.2d 284, 287-88 (7th Cir.1985). "The Commissioner has considerable discretion in assigning weight to medical opinions and is free to reject the opinion of any physician when the evidence supports a contrary conclusion." *Cheramie v. Apfel*, 1999 WL 1072544, at *5 (E.D. La. Nov. 24, 1999) (citing, *inter alia*, 20 C.F.R. §§ 404.1527(d)(2), 416.927(d), (e); *Greenspan v. Shalala*, 38 F.3d 232, 237 (5th Cir. 1994)).

Based on the totality of the evidence and the foregoing analysis, the court finds the ALJ's decision that Keehn is not entitled to disability insurance benefits is supported by substantial evidence in the record as a whole.

V. CONCLUSION

Although this court "might have weighed the evidence differently," *Culbertson, supra*, the court finds substantial evidence exists to support the Commissioner's decision.

Accordingly, **IT IS RECOMMENDED**, unless any party files objections[23] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that judgment be entered in favor of the Commissioner and against Keehn.

IT IS SO ORDERED.

DATED this 23rd day of March, 2002.

UNITED STATES DISTRICT COURT
MAGISTRATE JUDGE
PAUL A. ZOSS

[23]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).